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The Best Patients in the World: A Commentary on Military Medicine

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It was a sunny day last August and he had not been in Afghanistan more than a few months when this Lance Corporal's joint Army-Marine Corps unit came under rocket fire from a small Taliban assemblage at an elevated position. They were securing what up until that point seemed to be a deserted and benign village. The LCpl, a medic, left a few of his party to follow a friend into the shade where they could site the enemy more effectively with rifle combat optics (RCO) mounted on their M16s. Seconds later a rocket-propelled grenade (RPG) hit the site where he was previously standing, killing two soldiers in his unit. Small fragments peppered his torso and upper and lower extremities. One fragment penetrated his medial right ankle and blew through his calcaneus, leaving a gaping exit wound on the lateral side. It was a cold, cloudy evening last October when it was my duty, or more truthfully my honor, to clean and re-wrap his pre-surgical ankle with the Orthopaedic resident with whom I was taking the call.

When this Marine, a "C5 arrival" from Germany, was delivered to the National Navy Medical Center (NNMC) Bethesda, I was three weeks into my Orthopaedic Surgery clerkship. Prior to that moment I had spent the majority of my time caring for retired military who needed knee or hip replacements, shoulder or knee scopes. As none of the three major Navy medical training facilities in the U.S. (San Diego, Bethesda and Portsmouth) are Trauma 1 centers, I hadn't seen a fresh wound like this since my rotation at Westchester Medical Center where ATV and motorcycle accidents come in almost daily. Excepting the rare fractures secondary to gunshot wounds, I had not yet seen new fragmentary wounds in person.

That night on call left an impression not due to the physical characteristics, mechanism or scope of the trauma, but because of this young Marine's attitude and outlook. This patient, a guy younger than me, had been in the Marine Corps longer than I have been in the Navy, already returning from duty before I have had the chance to start a tour. He was a hardy but skinny kid that weighed in at barely more than 130 pounds by the time he arrived. His optimism never allowed him to cry. Not one complaint left his lips for the week I was there. He preferred talking about future plans, including his intention to apply to the Uniformed Services University of Health Sciences, which shares the campus with NNMC Bethesda. It could be called The United States Medical School because like any military branch academy it is included in our government's budget. I mentioned to him the Health Professions Scholarship Program (HPSP), of which I and many of our classmates from NYMC and most civilian medical schools, are a part of. And while he seemed to tolerate discussion of his part in the war, this Marine, like many military patients I have served, had his eyes on his future and his heart set on how to get there faster.

What is more, the interaction with the second-year Orthopaedic resident, a prior-enlisted Marine himself, was extraordinary. The Orthopaedic service was notified early in the day of the C5 arrival and the resident anxiously awaited his advent. The world stopped when this kid arrived on the ward. All other non-emergent patients took the backseat to our patient while we talked to him. I was instructed in no uncertain terms that this patient was the priority. We inspected, explored, cleaned and bandaged his ankle and leg wounds. During the hours I spent

with him, accompanying him to CT, ensuring his comfort, we exchanged stories. And while I missed a couple fractures in the ED, it was important to both of us. That night we learned from each other. He told me stories about the Marines and I told him about medical school. Meanwhile, his CT showed mush for what used to be a calcaneus.

This Marine typified the ideal Orthopaedic patient. In military hospitals, complaining was a rarity and recovery seldom required motivation external to the patient. I recall a similar patient, a Marine officer advanced in age but with a similar impetus for recovery as the enlistee above. I met this Lieutenant Colonel in the outpatient clinic in Point Loma, San Diego. His knee was severely limited by osteoarthritis and in need of replacement. He agreed to immediate surgery only on the condition he would be fully operational by June 2009 to return to Afghanistan. This officer is an example of a motivated, ideal patient in my mind. But he was just another example of the many military patients - active, reserve or retired, young or old, broken or healthy - that I encountered in clerkships last fall.

That night in October, I met a peer in the juxtaposing fields of medicine and the military. After his recovery and my graduation, I expect our paths in life to cross as he leaves active duty to go to school and I leave school for residency and active duty. While I called him Marine and he called me Sir, I couldn't help but think that in both arenas, he was the more experienced.

That young Marine has a wound that may result - or has resulted - in an amputation or at the very least a painful, limited gait for the rest of his life. His simple, positive outlook reminded me of the numerous patients I have cared for over the previous two months of military rotations. From shoulder scopes to major amputations, a vast majority of those patients all had that very same attitude. Across all branches and wars, these veterans highlighted a new respect I had not yet realized I had for them. They were, in so few words, the very best patients I have ever served.